DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

Physician's Reference

Date: _____

An application has been received from _____
Name

_____
Address

to be foster parents. As this is frequently a physically and emotionally demanding job, the Department of Children, Youth and Families is interested in the health of its applicants.

In order that we may expedite the processing of the application, we ask that you complete this form at your earliest convenience and return it to: _____

_____

Do you consider the applicant physically, mentally, and emotionally competent to be a foster parent?
[ ]Yes [ ]No

If no, please explain: _____

_____

Does the applicant have any chronic disease or illness [ ] Yes [ ] No
If Yes, please explain:_____

_____

What is your impression of the applicant's general health?_____

_____

Any additional comments? _____

_____

_____ _____
Physician's Signature Date

I hereby authorize the Rhode Island Department of Children, Youth and Families to obtain from
(Physician's Name)_____

_____
Address

medical and/or psychiatric information pertinent to me for the purpose of processing my application to be a foster parent. I understand any information release or obtained will not be released further. I understand that my consent can be terminated at any time.

_____ _____
Signature Date